Cryptosporidiosis

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: First and middle name: Maiden name: Suffix: Address line: Zip: City: State: County: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name: Facility phone: ( )- - Type:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other ____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death / /
Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom_____
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Cryptosporidium*** Type (e.g. serotype): ☐ *parvum* ☐ *hominis*

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Cryptosporidium*** Type (e.g. serotype): ☐ *parvum* ☐ *hominis*

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final / / Result: ☐ Positive ☐ Negative

Result date: _____

Organism: ***Cryptosporidium*** Type (e.g. serotype): ☐ *parvum* ☐ *hominis*

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Ext: Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Ext: Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Admission date: / / Discharge date: / /

Days hospitalized: _____

Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry):

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Is case immunosuppressed? ☐ Yes ☐ No ☐ Unk

Symptoms:

☐ Diarrhea	Onset date: / /	Duration: hours/days
☐ Fever	Onset date: / /	Duration: hours/days
☐ Vomiting	Onset date: / /	Duration: hours/days
☐ Abdominal cramps	Onset date: / /	Duration: hours/days
☐ Other	Onset date: / /	Duration: hours/days
☐ Unexplained Weight loss	Weight lost: lbs/Kg	

TREATMENT

Medications prescribed? ☐ Yes ☐ No ☐ Unknown

Medication: _____ Medication: _____ Medication: _____

Date started: / / Date started: / / Date started: / /

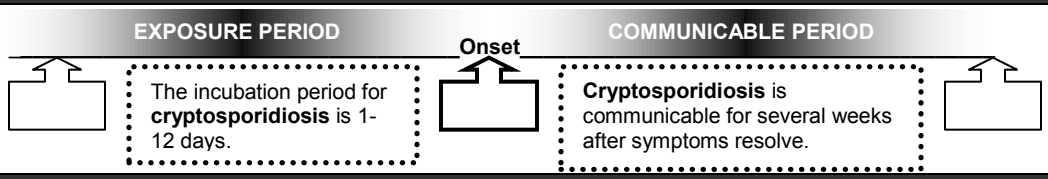
Dose: _____ Dose: _____ Dose: _____

Unit: ☐ mg ☐ ml ☐ IU Unit: ☐ mg ☐ ml ☐ IU Unit: ☐ mg ☐ ml ☐ IU

# of times a day:	Route:	# of times a day:	Route:	# of times a day:	Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Risk Factors/Travel Information – *In the 12 days prior to onset of symptoms did the case:*

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk	City in Iowa: _____	Departure date: / /	Return date: / /
Traveled within U.S.? ☐ Yes ☐ No ☐ Unk	State: _____ City: _____	Departure date: / /	Return date: / /
Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk	Country: _____	Departure date: / /	Return date: / /

Visit restaurants? ☐ Yes ☐ No ☐ Unk *If Yes, complete the table below:*

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attended Group Gatherings (e.g. weddings)? ☐ Yes ☐ No ☐ Unk *If Yes, complete the following table:*

Type of gathering	Address/Zip	Date visited	Foods consumed	Foods prepared	Others ill?
		/ /			☐ Yes ☐ No ☐ Unk
		/ /			☐ Yes ☐ No ☐ Unk
		/ /			☐ Yes ☐ No ☐ Unk

Dietary Information – *In the 12 days prior to onset of symptoms did the case consume the following:*

Unpastuerized milk: ☐ Yes ☐ No ☐ Unk	From dates consumed: / / / /	To dates consumed: / / / /	List all source/types: _____ List all brand names: _____
Other unpastuerized milk products: ☐ Yes ☐ No ☐ Unk	From dates consumed: / / / /	To dates consumed: / / / /	List all source/types: _____ List all brand names: _____
Other unpastuerized products (i.e. juice): ☐ Yes ☐ No ☐ Unk	From dates consumed: / / / /	To dates consumed: / / / /	List all source/types: _____ List all brand names: _____

Animal Exposures – *In the 12 days prior to the onset of symptoms did the case have the following exposures:*

Visit or live on a farm: ☐ Yes ☐ No ☐ Unk	Contact with manure: ☐ Yes ☐ No ☐ Unk	Contact with which animals on farm: ☐ Cows ☐ Sheep/goats ☐ Pigs
Visit any animal exhibits (petting zoo, county fair): ☐ Yes ☐ No ☐ Unk	Type of animals at exhibit: ☐ Cows ☐ Sheep/goats ☐ Pigs	
Exhibit name: _____	Address/Zip/County: _____	

Water Exposures*:*

Go swimming or have contact with recreational types of water? ☐ Yes ☐ No ☐ Unk *If Yes, complete the table below:*

Type	Location Type	When	Date visited (from / to)	Facility name/ Street address & Zip
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake ☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other_____	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	☐ Within 12 days before onset ☐ While having diarrhea ☐ 14 days after diarrhea stopped	/ / / /	
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake ☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other_____	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	☐ Within 12 days before onset ☐ While having diarrhea ☐ 14 days after diarrhea stopped	/ / / /	

Type		Location Type	When	Date visited (from / to)	Facility name/ Street address & Zip
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other________________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	☐ Within 12 days before onset ☐ While having diarrhea ☐ 14 days after diarrhea stopped	/ / / /	
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other________________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	☐ Within 12 days before onset ☐ While having diarrhea ☐ 14 days after diarrhea stopped	/ / / /	
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other________________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	☐ Within 12 days before onset ☐ While having diarrhea ☐ 14 days after diarrhea stopped	/ / / /	
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other________________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	☐ Within 12 days before onset ☐ While having diarrhea ☐ 14 days after diarrhea stopped	/ / / /	

In the 12 days prior to the onset of symptoms:

Drinking water supply

Home:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**School:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well
Work:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**Child care:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well

Did patient use a water filter at home? ☐ Yes ☐ No ☐ Unk What type: ______________________

Other Exposures – *In the 12 days prior to the onset of symptoms*

Wear diapers ☐ Yes ☐ No ☐ Unk **Have contact with diapers:** ☐ Yes ☐ No ☐ Unk

Have contact with immunocompromised person: ☐ Yes ☐ No ☐ Unk Setting: ☐ Home ☐ Work ☐ Other

Have sex with someone with similar symptoms: ☐ Yes ☐ No ☐ Unk Sexual preference: ☐ Hetero ☐ Homo ☐ Bisexual ☐ Unknown

Other risk factors

Do you have a child in child care? ☐ Yes ☐ No ☐ Unk List child care names: ______________________________________

____

____

CONTACTS

Number of people living in case's household: _____

Are there close contacts of the case with same symptoms: ☐ Yes ☐ No ☐ Unknown

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same exposures	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Restaurant ☐ Gatherings ☐ Food ☐ Animal ☐ Water	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:	List symptoms	Symptom onset date	Same exposures	Is contact a case?

☐ Spouse	☐ Sexual contact	/ /	☐ Restaurant	☐ Yes
☐ Child	☐ Family member (non-household)		☐ Gatherings	☐ No
☐ Sibling	☐ Friend/acquaintance		☐ Food	
☐ Roommate	☐ Contact- work/school/etc		☐ Animal	
☐ Parent/ guardian	☐ Unknown/Other		☐ Water	

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same exposures	Is contact a case?
☐ Spouse	☐ Sexual contact		/ /	☐ Restaurant	☐ Yes
☐ Child	☐ Family member (non-household)			☐ Gatherings	☐ No
☐ Sibling	☐ Friend/acquaintance			☐ Food	
☐ Roommate	☐ Contact- work/school/etc			☐ Animal	
☐ Parent/ guardian	☐ Unknown/Other			☐ Water	

If this contact is a case create a new event and/or case for this contact.

NOTES: